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**Out of Hours service review Board update and assurance**

**Strategic Objectives**

This report relates to or provides assurance and evidence against the following Strategic Objective(s) of the Trust

1) Driving Quality Improvement

(Goals: patients will be safe from harm; patients will achieve the clinical outcomes they want; and patients and carers will have an excellent experience)

2) Delivering Operational Excellence

(Goals: our services will be effective and efficient; information will be translated into knowledge; and our planned surplus will be delivered)

5) Developing Leadership, People and Culture

(Goals: staff satisfaction will be in the top 20% of Trusts nationally; our staff and teams will be high-performing; and we will recruit and retain an excellent workforce)

**Recommendation**

The committee is asked to note this paper and acknowledge the progress that the service has made against the recommendations and the outstanding actions.

**Author and title:** **Mrs Christine Hewitt, Head of Urgent and Ambulatory Care**

**Lead Executive Director: Mr Dominic Hardisty, Chief Operating Officer**

**Situation**

Commencing in June 2017, the Oxfordshire Out of Hours Primary Care service (OOHs) underwent an end to end review to evaluate, assess and consider recommendations to assist in delivering to the commissioned primary aims and objectives. A report outlining the outcomes and recommendations from this review was presented the executive board in January 2018. The purpose of this paper is to provide an update to the board regarding the progress against the identified actions, to identify any outstanding actions and to provide the board with assurance that the service is safe.

In November 2016, the CQC undertook an inspection of the out of hours service the outcome of this was a rating of ‘needs improvement’. In March 2018, the service was reassessed against the areas presented in the November inspection. The outcome of the reassessment was a draft rating of ‘good’, with a recommendation regarding 5 key areas which are now being actioned.

Patient safety and experience within the service has continued to remain stable and positive, complaints and incidents have remained low and patient experience has been good as identified within the I want Great Care feedback. The service has been active in promoting this.

Progress is being made on the compliance to quality requirements although this is slow and remains inconsistent. Further actions have been identified with plans to improve particularly the flow into urgent base appointments, the service is confident that this will improve compliance in the next two months.

To support this the service has in draft an updated demand and capacity model, this will be moved forward now with pace to support shift rostering for 18/19, further recruitment and an opportunity to exert better financial control.

**Background**

Key recommendations from the Out of Hours review and outcome of the data incident identified;

1. That commissioners take a more active role in the service to understand and support the service to respond to challenges which require a ‘whole system’ response. Undertaking supported quality review visits in the service will support assurance.
2. That the service operational and clinical leads agree ‘Safe Staffing levels’ with a clear baseline of the minimum numbers of clinicians required for each shift based on historical activity data and report this on a regular basis to ensure appropriate Trust Board level oversight
3. That the Service revises the current contractual performance indicators with OCCG to take account of changes to patient pathways since 111 introduction and national guidance
4. That the service finalises an OOH reporting suite by the end of March 2018 with implementation within the Trusts Business Intelligence team
5. That the Service considers the skill mix and configuration of clinical teams working in OoH to take account of managing patient groups in a more appropriate manner. The development a business case to create a ‘catheter team’ to reduce impact on GP caseload is an example of one such option.
6. That OCCG reviews OoH activity ‘by surgery’ and agree action plan to reduce activity from surgeries with a high level of avoidable OoH activity per head of registered practice population.
7. That the service operational and clinical leads implement the revised service management structure with clear job descriptions and meaningful objectives for all staff involved.
8. That the service clinical leads evaluate individual clinical performance and act to ensure a relative consistency in terms of productivity, efficiency and effectiveness amongst the clinical workforce.

The CQC review identified 5 areas for improvement; Compliance to DBS checks for GP’s and safeguarding children, the management of controlled drugs and prescriptions, chaperone training for driver/receptionists and staffing against the GP roster.

**Assessment**

January through to March have been busy months with high demands on the service, clinical staffing has been on occasion a challenge but the service continues to be able to evidence a good standard of patient experience, as identified within the most recent patient survey (April 18) where 97% of patients identified that they were likely to recommend the service. The credit for this must be given to the continued high standard and professional care afforded by the clinical and medical staff and the supporting management. Since January the service has managed 43,906 patient contacts and received 3 complaints and 30 concerns, 0.1%.

The table below identifies the actions identified in the OOHs service review and CQC recommendations and identifies the progress that the service has made to date.

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| Action | Progress to date |
| Commissioners take a more active role in the service to understand and support the service to respond to challenges which require a ‘whole system’ response.  | The oversight and understanding of the service by the CCG has improved. This has been supported by a new appointment with experience in Out of Hours services. The first quality review is to take place on the 5th June.This action is on track |
| That the service operational and clinical leads agree ‘Safe Staffing levels’ with a clear baseline of the minimum numbers of clinicians required for each shift based on historical activity data and report this on a regular basis to ensure appropriate Trust Board level oversight | Demand and capacity modelling has been completed. Example rotas are being built to support sign off from the service clinical leads. Rotas will then be published for the next 6 months.This will be some work going forward to consult where regular shifts change.This is due to be completed by July 18 – on track |
| That the Service revises the current contractual performance indicators with OCCG to take account of changes to patient pathways since 111 introduction and national guidance | A draft set of performance indicators has been prepared. The start and end times have been agreed by OCCG.On track to be completed End of June 18 |
| That the service finalises an Out of Hours reporting suite by the end of March 2018 with implementation within the Trusts Business Intelligence team | The data flows have now been agreed and received from Adastra. The building of the reporting suite remains outstanding due to competing priorities. The service team manually reports the data. This continues to be a risk to the service. |
| That the Service considers the skill mix and configuration of clinical teams working in OoH to take account of managing patient groups in a more appropriate manner.  | Within the service further health care assistants have been utilised to support patients who require a home visit or who attend base appointments, by providing tasked focused support- catheter management, management of dressings or base line observations for those waiting to be seen, this has helped in supporting flow and improving productivity. Catheter team business case outstanding. To be completed by end June 18 |
| That OCCG reviews OoH activity ‘by surgery’ and agree action plan to reduce activity from surgeries with a high level of avoidable OoH activity per head of registered practice population. | This action is outstanding; it is anticipated that going forward the project associated with the frail elderly pathways will support this. |
| That the service operational and clinical leads implement the revised service management structure with clear job descriptions and meaningful objectives for all staff involved.  | All posts have now been appointed to resulting in a further 2 managers to support the team. All staff within the team have had PDR’s and job descriptions have been updated where required.Complete |
| That the service clinical leads evaluate individual clinical performance and act to ensure a relative consistency in terms of productivity, efficiency and effectiveness amongst the clinical workforce | Several clinicians have now been reviewed and supported to improve speed and quality of consultations. This has been supported by regular communication from the medical advisors. Processes are now in place to continue reviews of effectiveness and safety within the NQR6 audits Complete |
| Child safeguarding training for all GPs had not been recorded or was incomplete. | This is now above 90% for all GP’s. (4 outstanding L2 and 10 outstanding with L3) |
| Chaperone training programme for non-clinical staff (beyond the induction period) had not been completed | This is now complete |
| There were several GP’s who did not have a DBS certificate. | 1 GP now has an up to date DBS check in place. 2 GPs DBS checks are being processed on Care check. 1 GP has arranged for their ID to be collected on 3.6.18 to initiate processing with HR.This is being reviewed on a weekly basis.  |
| The tracking of blank prescriptions was inconsistent between different OOH bases | The matron walk around will review the management of prescriptions monthly this will report in the UAC and quality committee. In place. |
| Review calibration of blood glucose monitors and ensure staff are aware of best practice guidelines for use. | Practice have been developed and rolled out across all bases and in addition training has been delivered. Complete |
| Review and improve staffing levels with a view to achieving the 98% target for session fulfilment. | The Oohs service continues to face challenges in attracting and recruiting GP’s and non-medical staff. However there has been a steady stream of clinical and medical staff attracted to the service, the service is continuing to support registrar training working closely with the Deanery to utilise experienced ST3’s to support flow in a supervised way and to attracted newly qualified GP’s. The service continues to review the case mix to find alternative ways to manage the demand that would better support patient care. Since January patients have been directed from 111 to pharmacies for repeat prescriptions taking away a steady flow of such requests.This action is ongoing and continues to present a clinical risk. |
| Audit trail for CD’s | This action was specific to Oxford base; a process has now been agreed where the CD’s are delivered when the service is open and receptionists have been trained in receiving them. |

**Recommendation**

There has been positive progress to improving the OOHs service against the areas identified, the service has a stable management team which is continuing to complete any outstanding actions.

The executive team are requested to note the outstanding actions and the mitigation that has been put in to manage the risks, it is requested that going forward the service provides a quarterly update report to the executive team to identify progress and provide assurance.